Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TX HEALTH DBA INJURY 1 DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name
STANDARD FIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-11-3523-01

MFDR Date Received
JUNE 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The treatment that was provided is part of his compensable injury that he sustained on 10/07/09. Also, the services were preauthorized."

Amount in Dispute: $3,117.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The Carrier has determined a Contested Case hearing was held subsequent to the dates of service, which determined the psychological conditions were related to the compensable injury. In that review, however, it was also determined that the Provider did not timely file for Medical Fee Dispute Resolution for all dates of service at issue. Consequently, the Carrier is issuing reimbursement for the timely-filed disputed dates of service (06-16-2010 to 11-05-2010), but is maintaining denial of reimbursement for the earlier dates of service on the basis that the Provider has waived the right to reimbursement by failing to timely file for Medical Fee Dispute Resolution."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 5, 2010 May 12, 2010 May 18, 2010 May 26, 2010 June 11, 2010	CPT Code 90806	$140.59/day x 5 dates = $702.95	$0.00
May 5, 2010 May 12, 2010 May 26, 2010 June 11, 2010	CPT Code 90901	$603.72/day x 4 dates = $2,414.88	$0.00
June 16, 2010 June 23, 2010 June 25, 2010 November 5, 2010	CPT Code 90806, 90901, 96151	$0.00	$0.00

TOTAL		$3,117.83	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W12-Extent of injury. Not finally adjudicated.
   - CTWL-218-Based on entitlement to benefits. Not reimbursable because the workers compensation claim has been denied based on compensability, disability, or a combination of reasons.
   - TXF4-W1-Wrk comp state fee schedule adjustment. The procedure billed requires preauthorization. If preauthorization was received reimbursement is made in accordance with the TXMFG.
   - TX05-W1-Workers compensation fee schedule adjustment. Payment for this service is bundled into the payment for other services not specified.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - Z001-16-Clm/service lacks info which is needed for adjudication. For explanation of a non-payment by the adjuster. Please contact the adjuster on file.

Issues

1. Does a dispute exist for services rendered from June 16, 2010 to November 5, 2010?
2. Does the dispute contain timely filing issues?

Findings

1. The respondent states in the position summary that "…the Carrier is issuing reimbursement for the timely-filed disputed dates of service (06-16-2010 to 11-05-2010), but is maintaining denial of reimbursement for the earlier dates of service on the basis that the Provider has waived the right to reimbursement by failing to timely file for Medical Fee Dispute Resolution."

   On January 16, 2013, the Division contacted the requestor's representative, Judith Guerra, and confirmed the respondent's position that payment had been received for dates of service June 16, 2010 through November 5, 2010.

   The Division concludes that the fee dispute has been resolved for the services rendered from June 16, 2010 through November 5, 2010; therefore, they will not be considered further in this decision.
2. 28 Texas Administrative Code §133.307(c)(1) states "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request.

   The request for medical fee dispute resolution was received by the Division's MDR Section on June 14, 2011.

   28 Texas Administrative Code §133.307(c)(1) states "(A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute".

   Review of the submitted documentation finds that the request for medical fee dispute resolution does not involve issues identified in subparagraph (B).

   The disputed dates of service are May 5, 2010 through November 5, 2010. Dates of service May 5, 2010 through June 11, 2010 are past the one year filing deadline. The Division concludes that the requestor has failed to timely file the dispute for dates of service May 5, 2010 through June 11, 2010 with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute rendered from May 5, 2010 through June 11, 2010. The respondent has paid for the remaining disputed services rendered from June 16, 2010 through November 5, 2010. As a result, the amount ordered is $0.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	1/18/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.